

Case: _____ Control: _____

Date Received: _____

Type/Source: _____ / _____

Org. Code: _____

Report of Accident/Illness

SAFETY & HEALTH MANAGEMENT INFORMATION

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report: Accident Illness
2. Name: _____ (Last, First, M.I.) 3. SSN: _____
4. Occupation: _____ 5. Phone: _____
6. Date of Birth: _____ 7. Sex: Male Female
8. Date/Time of Accident/Illness: _____ Time: _____ AM PM

9. Duty Station Address: _____ 10. Location of Incident: _____

11. Description of Incident: _____

12. Extent of Injury or Illness and Body Parts Affected: _____

Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR

13. Medical Treatment? Yes No 14. Lost Time? Yes No

15. Investigator's Name: _____ 15. Investigation Date: _____

16. Findings: _____

17. Amount of Property Damage: \$ _____

18. Corrective Action: _____

19. Completion Date: _____ Estimated Actual

Investigator's Signature: _____ Date: _____

Title: _____ Phone: _____